Community First Medical Center

HOSPITAL FINANCIAL ASSISTANCE APPLICATION (CFMC)

Name of Patient: _____

Date: _____

Date(s) of Services at Hospital: _____

Account Number: _____

Thank you for choosing Community First Medical Center for your healthcare services. We offer a variety of financial assistance programs to meet our patient's needs. Our programs apply **only** to Community First Medical Center hospital charges. Please be aware you will receive separate bills from each independent practitioner or groups of practitioners for care, treatment, or services provided. The Financial Assistance Program does not apply to these charges.

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Community First Medical Center determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help Community First Medical Center determine whether you qualify for any public programs. Applying for such programs may be required prior to applying for a Financial Assistance Program. We will assist patients with the identification of state funded public programs and the enrollment process.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following your date of discharge or receipt of outpatient care. Community First Medical Center will extend these timelines if you need additional time to gather information or if circumstances dictate that additional time is necessary. In completing this form, you acknowledge that you have made a good faith effort to provide all information requested in the application to assist Community First Medical Center in determining your eligibility for financial assistance.

Community First Medical Center Financial Assistance Programs include:

Program	Available to	Description	How to Apply
Financial Assistance	Uninsured and Insured Patients	Offers free care or discounted care based on family size and income according to the Federal Poverty Guidelines	Complete the Financial Assistance Program Application
Automatic Uninsured Self-Pay Discount	Uninsured Patients	Offers an automatic 50% discount	No application necessary
Catastrophic Discount	Uninsured and Insured Patients	Limits the out-of-pocket costs when medical debts specific to medical care at our Hospitals exceed 15% of the patient's family gross income	Determine if your out-of-pocket expenses exceed 15% of family gross income. If so, complete the Financial Assistance Program Application
Payment Plan Program	Uninsured and Insured Patients	Assists patients with their financial obligations by establishing payment arrangements	Contact a Financial Counselor* or Customer Service at **(773) 794-7626**

To help us determine if you are qualified to receive financial assistance, please complete, sign and return this application along with copies of any required documents.

Community First Medical Center

Hospital Financial Assistance Application

NOTE: This application is for Community First Medical Center hospital charges only. It does not include independent physician professional charges.

Program Applying For:

- ☐ Financial Assistance (Free/Discounted Care)
- ☐ Catastrophic Discount

Section One: Demographic Information

Patient Name (or Applicant if Patient is a minor): _____

Patient Date of Birth: _____

Patient Address: _____

Patient Home Phone: _____

Patient Cell Phone: _____

Patient Email Address: _____

Patient Social Security Number (not required if you are uninsured): _____

Spouse/Partner/Guarantor: _____

Spouse/Partner/Guarantor: _____

Spouse/Partner/Guarantor Home Phone: _____

Spouse/Partner/Guarantor Cell Phone: _____

Is the patient an Illinois resident: Yes No

Was the patient a victim of a crime: Yes No

Was the patient involved in an alleged accident: Yes No

Residency Identification. Community First Medical Center needs to verify where you currently reside as part of this process. Acceptable forms of residency identification can include any one of the following: State-Issued Driver's License; State-Issued Identification Card; recent residential utility bill; a lease agreement; a vehicle registration card; a voter registration card; mail addressed to you from a governmental agency or other credible source; a statement from a family member who resides with you at the same address and presents verification of residency; a letter from a homeless shelter, transitional house or other similar facility verifying that you live at the facility; any items identified under the Income Verification section (below); verification of your address from your employer; or any other reasonable form of information that verifies your address as deemed acceptable by Community First Medical Center. To the extent you cannot provide any identification that verifies your residency, Community First Medical Center will rely on the residency information you provide above.

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Hospital Financial Assistance Application **Patient Name:** _____

Section Two: Family/Dependents/Household Information

Number of persons in patient's family/household: _____

Number of persons who are dependents of the patient: _____

Ages of patient's dependents: ____, ____, ____, ____, ____, ____, ____, ____, ____, ____

Section Three: Family Income and Employment Information

Name of Patient's Current Employer (if employed): _____

Address of Patient's Current Employer (Line 1): _____

Address of Patient's Current Employer (Line 2): _____

Phone Number of Patient's Current Employer: _____

Name of Spouse's/Partner's Current Employer (if employed): _____

Address of Spouse's/Partner's Current Employer (Line 1): _____

Address of Spouse's/Partner's Current Employer (Line 2): _____

Phone Number of Spouse's/Partner's Current Employer: _____

Name of Parents/Guarantor's Current Employer (if employed): _____

Address of Parent's/Guarantor's Current Employer (Line 1): _____

Address of Parent's/Guarantor's Current Employer (Line 2): _____

Phone Number of Parent's/Guarantor's Current Employer: _____

Address of Parent's/Guarantor's Current Employer (Line 1): _____

Address of Parent's/Guarantor's Current Employer (Line 2): _____

Phone Number of Parent's/Guarantor's Current Employer: _____

If the patient is a minor, is a former spouse/partner financially responsible for patient's medical care due to a dissolution/separation agreement: Yes No

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Hospital Financial Assistance Application **Patient Name:** _____

Section Three: Family Income and Employment Information (continued)

Please list all **gross monthly family income**, including cases in which a spouse or partner is guarantor for the patient or in which a parent or guardian is a guarantor for a minor, from sources such as:

	Patient/Applicant	Spouse/Partner/Guarantor
Wages	$	$
Self-employment	$	$
Unemployment compensation	$	$
Social Security	$	$
Social Security Disability	$	$
Veterans' Disability	$	$
Private Disability	$	$
Workers' compensation	$	$
Temporary Assistance for Needy Families	$	$
Retirement Income	$	$
Child support/alimony/spousal support	$	$
Other income	$	$
Total monthly income	$	$

Income Verification from Patient, Spouse and/or Guarantor. Community First Medical Center needs to verify your income and your family's income as part of this process. Your application will not be approved without proof of income and supporting documentation. Acceptable forms of income verification can include any one of the following: a copy of your most recent tax return; a copy of your most recent w-2 forms or 1099 forms; copies of your two most recent pay stubs; written income verification from your employer if you are paid in cash; or any other form of income verification that is deemed acceptable by Community First Medical Center.

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Section Four: Insurance/Benefit Information:

Which forms of insurance do you currently have? (please check all that apply and provide any supporting documentation)

- ☐ Private Health Insurance
- ☐ Medicare
- ☐ Medicare Part D
- ☐ Medicare Supplement
- ☐ Medicaid
- ☐ Veterans Benefits
- ☐ I do not have insurance

If you have private health insurance please provide the following information:

Name of Patient's/Applicant's Insurance Company: _____

Insurance Company Address: _____

Group Number: _____

Policy Number: _____

Phone Number: _____

Name of Spouse's/Partner's/Guarantor's Insurance Company: _____

Insurance Company Address: _____

Group Number: _____

Policy Number: _____

Phone Number: _____

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Section Five: Asset Information

Please list your assets and the estimated value of those assets.

	Patient/Applicant	Spouse/Partner/Guarantor
Checking Accounts	$	$
Saving Accounts	$	$
Certificates of Deposit	$	$
Stocks	$	$
Mutual Funds	$	$
Automobiles or other vehicles	$	$
Real Property	$	$
Health savings/flex spending accounts	$	$
Total	$	$

Asset Verification. Community First Medical Center needs to verify your assets (and the value of those assets) as part of this process. Acceptable documentation may include statements from financial institutions or some other third party verifying the valuation of your assets. To the extent you cannot provide any third party verification of the value of your assets, Community First Medical Center will rely on any asset valuations you provide above.

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Section Six: Family Expenses

Please list all **monthly family expenses** from sources such as:

	Patient/Applicant	Spouse/Partner/Guarantor
Housing	$	$
Utilities	$	$
Food	$	$
Transportation	$	$
Child Care	$	$
Loans	$	$
Medical Expenses	$	$
Other Expenses	$	$
Total Monthly Expenses	$	$

BASED UPON THE INFORMATION RECEIVED WITH THIS APPLICATION, IF IS DETERMINED THAT THE PATIENT MEETS THE PRESUMTIVE ELIGIBILITY CRITERIA SET FORTH IN ILLINOIS ADMINISTRATIVE CODE SECTION 4500.40 OR IS OTHERWISE PRESUMATIVELY ELIGIBLE BY VIRTUE OF THE PATIENT'S FAMILY INCOME, THE PATIENT WILL NOT BE REQUIRED TO COMPLETE THIS SECTION.

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Patient/Applicant Signature: _____

Date: _____

Spouse/Partner/Guarantor Signature: _____

Date: _____

Return completed form and supporting documents to:
Community First Medical Center
5645 W. Addison St.
Chicago, IL 60634
Attention: Cashier Department – 1st Floor

If you have any questions or need additional assistance, please contact us at **(773) 794-7626** to obtain additional information on our Financial Assistance Programs.